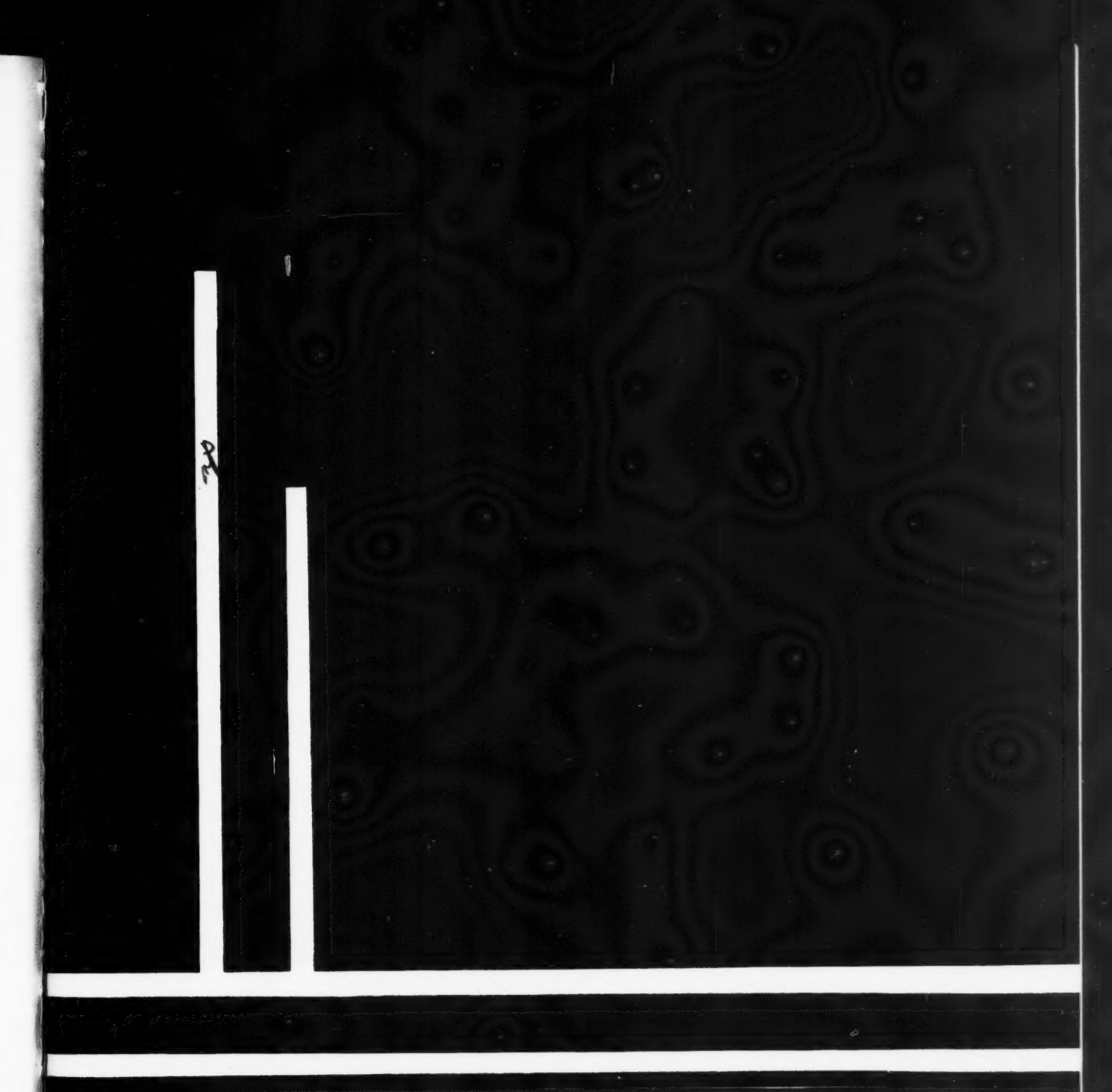

MAY, 1940

THE CANADIAN HOSPITAL

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Harvey Agnew, M.D.,
Editor

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Hospital Contracts with Federal Government to be Clarified

Canadian Hospital Council Sub-executive Confers with Department of Pensions and National Health Officials

CONSIDERABLE progress was made in the clarification of the difficulties which have arisen from time to time over the hospitalization in general hospitals of soldiers and ex-soldiers at a conference held in Ottawa on April the 18th, between representatives of the Department of Pensions and National Health and of the Canadian Hospital Council.

The Background

For some time there has been a divergence of opinion between some of the contract hospitals and Ottawa over the services to be supplied by the hospitals for the care of soldiers, ex-soldiers, mounted police and others, and the remuneration of the hospitals for such services. Much correspondence has taken place between individual hospitals and the Department of Pensions and National Health and between the hospitals and the Department and the Canadian Hospital Council. Federal and other contracts have been under discussion at the Canadian Hospital Council sessions for several years back and in 1937 the Council adopted the basic policy that no hospital contract should be entered into by hospitals at less than the actual cost.

During the summer of 1939 a number of hospitals were in communication with the Council relative to new contracts with the federal government then under consideration. Although favouring some of the features of the new contracts, the Council notified the Association secretaries in August that, in making fresh contracts, the hospitals should bear in mind (1) the desirability of avoiding ambiguity and, (2) the policy previously adopted by the Canadian Hospital Council that no contracts should be entered into at less than actual cost. With the outbreak of war and the admission of many C.A.S.F. patients, these contracts became of added concern to the hospitals. Accordingly, it was arranged that this conference should be held to clarify the whole situation.

The Conference

At this conference the Department of Pensions and National Health was represented by Dr. Ross Millar, Director of Medical Services, Mr. H. A. Bridges, Departmental Solicitor, and Dr. A. F. Macaulay. The Canadian Hospital Council was represented by Dr. George F. Stephens, President, Mr. R. F. Armstrong, Executive Member, and Dr. Harvey Agnew, the Secretary-Treasurer. Prior to the conference the Council had been in touch with its executive members and officers of the various component associations and with many contract hospitals. They were thus in a position to express the composite viewpoint of the hospitals.

On behalf of the hospitals, Dr. Stephens pointed out that the hospitals have neither the desire nor the expectation to make any profit from the care of Canadian soldiers and ex-soldiers. The hospitals are desirous, however, of receiving fair and adequate remuneration for the services which they are rendering. On behalf of his department, Dr. Millar emphasized that it is not the intention of the Department to ask the hospitals of Canada to perform any service for the Department at less than cost. He pointed out, too, that the Dominion Government is now providing hospitalization for many individuals who otherwise would have been a charge upon the municipalities and the provinces.

Uniform Contract

It was agreed that much of the difficulty would be overcome if the present diversity of contracts could be simplified and a contract, uniform

as to the services enumerated and so worded as to minimize ambiguity, could be adopted. In view of the fact that there is considerable variation in the facilities available in various contract hospitals, it was agreed that the model contract form should embody certain features as inclusive and enumerate others as "extras", the hospitals to be remunerated for such extras through a separate schedule of payments. A draft of this model contract was then prepared. The details, which will be subject primarily to the approval of the Minister of the Department of Pensions and National Health and, finally, to that of the individual participating hospital, will be published, it is hoped, in our June issue, but the general provisions with respect to services may be synopsized as follows:

1. *To be covered by inclusive rate*
   Ward Accommodation.
   Routine floor nursing as supplied with ward accommodation. This will cover special attention to seriously ill patients, but not private duty nursing.
   Laundry.
   Full intern service in such hospitals as maintain interns.
   Ordinary medications, including glucose injections (see "not included" list).
   Dressings, splints and appliances.
   Routine laboratory examinations, but not those involving extensive or unusual examinations.
   Use of operating room.
   Anaesthetic materials.
   Physical therapy only as supplied without charge to other patients.
   All other necessary hospital supplies and appliances which would ordinarily be furnished on a ward service without extra charge.

2. *Items not included*
   Sera, biologicals, bottled beverages, special proprietary medicines and pharmaceutical preparations not included in the British Pharmacopoeia, the United States Pharmacopoeia or the Canadian Formulary.
   Laboratory examinations other than routine.
   Blood transfusions.
   Intravenous therapy other than saline and glucose.
   Physical therapy other than as provided above.
   X-ray diagnosis and therapy.
   Basal metabolism.
   Electrocardiograms.
   Orthodiagrams.
   Radium.
   Oxygen and CO_2-O_2 therapy.
   Professional service of the anaesthetist.
   Private duty nursing and nurses' board.

Comment

In some hospitals the contract provides for ward, semiprivate and private accommodation. It was agreed that the basic contract should be for ward accommodation only. Where higher priced accommodation is desired or necessary, such should be arranged for on a basis determined between the hospital and the Department; in such cases inclusive services and extras should follow the basis outlined above.

Should x-ray service be included or not? As there is a wide divergence of opinion in the medical profession and the hospital field concerning the inclusion of radiological service in contracts of various types, it was agreed to omit this from the inclusive rate and consider it as an extra. This, of course, would have some bearing on the per diem rate to be paid. The services of the anaesthetist, now included in many contracts, is to be omitted. The definitions of ordinary medication and of routine laboratory examinations are subject to some ambiguity; by the elaboration of examples in the contract form, it is anticipated that most of the difficulties of interpretation can be overcome.

It will be noted that the inclusive list of services has been reduced. This seemed advisable in view of the fact that there is such a divergence of equipment and facilities in the various contract hospitals. By this arrangement the basic rate can be rendered more uniform than otherwise would have been possible.

Remuneration of Hospitals

Considerable discussion took place relative to the basis of payment to hospitals. Previous to the meeting the Canadian Hospital Council corresponded with its executive committee, with the various hospital associations and with numerous contract hospitals. The general viewpoint expressed was that a uniform fee to all hospitals was not possible. This opinion was not an entirely unanimous one in the hospital field, for in two instances (New Brunswick Hospital Association and the Maritime Conference of the Catholic Hospital Association) the same rate for all hospitals was favoured. The Department pointed out that this would be definitely unfair, for it is obvious that some of the smaller, less well equipped hospitals without adequate laboratory and other facilities could not possibly give the patients the same service as could be expected in the fully equipped and staffed, highly departmentalized hospital operating at a much higher cost.

The Department is willing to pay the full cost of caring for their patients, but does object to paying a rate designed to cover loss sustained on the charity service and the out-patient department. It was pointed out, also, that very few hospitals can furnish accurate data on the actual cost of caring for a soldier or ex-soldier on the medical or surgical wards. Average per diem costs vary widely in their method of compilation and very frequently include improper or questionable items of expenditure. It is anticipated that the early adoption of a uniform basis of accounting, as urged by the Council, will solve this difficulty.

It was revealed by the Department, too, that a large number of contracts have been signed in the past few months on an all-inclusive basis. Whether or not these cover costs the Committee was not in a position to decide.

Graded Basic Rate Plus Extras

Rather than have one flat rate, it was agreed that for the inclusive services there should be a model graded scale of payment, depending upon the facilities of the hospital and its ability to give the required service. This would be supplemented by payment for authorized extras, such payment to be according to the Department schedule, or possibly on a per diem basis for each extra.

The scale of payments in the final

analysis must needs be a matter of arrangement between the individual hospital and the Department. It is anticipated that a graded scale of per diem payments will be arranged for the inclusive services, plus payment for the extras cited. These will be paid for at Departmental schedules which will be subject to modification to meet individual situations.

It was stated at the meeting that the Departmental officials will be willing to reconsider any contract, if it is found that such is working to the disadvantage of the hospital. Every hospital also has the privilege of submitting an analysis of its actual costs to the Department if a revision of the rates seems in order.

Medical Services

Contrary to belief in certain areas, the Department does not expect hospitals to pay for clinical services by practising doctors. The Department provides medical care in each area and has its own financial arrangement with the individual member of the medical profession.

It should be noted, that the Canadian Hospital Council sub-executive did not feel free to make any representation which would be binding upon any hospital. In the final analysis the arrangements are a matter of agreement between the Department and the hospital, but the situation has been considerably clarified by the defining of a basic type of contract, which it is recommended that all contract hospitals, barring local reasons, should follow. Negotiations are still proceeding and further announcements will appear in due course.

Health and Sanitation Section of National Building Code Now Completed

Part 5 of the National Building Code, dealing with requirements bearing on health and sanitation, has now been completed and is available in stencilled form. This section of the National Building Code has chapters on general requirements on dimensions of rooms, on lighting and ventilation, on heating facilities, on plumbing facilities and on other requirements. It is a very practical compilation of minimum modern requirements and should be an excellent basis for the revision of building codes in various areas. While designed for all buildings, most of its provisions are applicable to hospital and nursing home construction.

It is required that every assembly room shall be provided with a system of mechanical ventilation unless the space within such room exceeds 150 cubic feet for each unit of seating capacity. Where seats are not fixed, 6 square feet of floor area is taken as one unit of seating capacity. Neither the space above any stage nor the area of such stage shall be considered in computing volumes and seating capacity. Minimum air supplies required for various rooms are set forth.

The minimum wattage requirements per square foot of floor area in various types of rooms are given. It is stipulated that all electrical wiring and facilities shall conform to requirements of the Canadian Electrical Code, Part 1, dated 1939, as published by the Canadian Engineering Standards' Association or such more restricted regulations as the authority having jurisdiction may stipulate. Where artificial lighting is provided from non-electrical sources, the Code recognizes the regulations set forth in "National Fire Codes for Flammable Liquids and Gases 1938", by the Ontario Chapter, Canadian Division of the American Society of Heating and Ventilating Engineers.

Minimum plumbing requirements are set forth at some length. Thermal insulation of walls and roofs is set forth and the report accepts the heat transmission coefficients for roofs as approved by the Ontario Chapter, A.S.H.V.E. Further sections include one on rat-proofing of buildings and garbage chutes; there is also a section setting forth the actual sound transmission loss of various types of typical wall construction.

This report is of practical value to everyone interested in hospital construction. It should be pointed out that these requirements are not mandatory, at the present time, but have been designed as a standard code to assist in the formulation of building codes in various communities. For some areas the local building codes may need to be more rigid than those set forth in this report.

Dr. G. S. Williams Overseas

Major Gerald S. Williams, superintendent of the Children's Hospital of Winnipeg, has been granted leave of absence for military service. Major Williams is now somewhere in England.

Canadian Paediatrician Honoured

Dr. Alan Brown, physician-in-chief of the Hospital for Sick Children, Toronto, has been elected to fellowship in the Royal College of Physicians of London, England.

Municipal Clinic of Radiology Opened in Montreal

A clinic of radiology has been opened by the city at the Laurier Health Centre. This clinic is for diagnosis only and is intended for the suspected case of tuberculosis or contact who cannot afford a radiograph or does not want to go to an existing anti-tuberculous institution. Patients may be referred to the clinic by the family physician who will be sent a confidential report on the films taken. No treatment will be given. The Clinic will be open to the public during week days, except for Saturday afternoon, and on Tuesday evenings.

Minor Fire in Basement Damages Equipment

Flames damaged several cots and mattresses when a fire started in the basement of the new addition of the Edmonton General Hospital. The building itself was not damaged. The fire is believed to have been started when a cigarette butt was dropped into excelsior surrounding the metal ends of new cots.

Observations on the First Year's Experience of the Canadian Intern Board

Preliminary Comment on a Co-operative Plan of Making Intern Appointments

SUFFICIENT time would now seem to have elapsed to warrant the making of some preliminary observations on the operation of the Canadian Intern Board during the past winter. It will be recalled that the Canadian Association of Medical Students and Interns, in an endeavour to eliminate much of the chaos and confusion hitherto surrounding the appointment of interns, organized a Canadian Intern Board (C.I.B.) which, with the co-operation of the senior students and the hospitals, worked out a plan for the allocation of interns to hospitals.

This plan did not apply to those students whose internship is an undergraduate one, as in Manitoba and Dalhousie, nor to the arrangements in Montreal where the interns are assigned to certain hospitals. It did apply particularly to graduates of Queens, Toronto, Western Ontario and Alberta.

The Plan

The plan, in brief, requires all final year students in the colleges participating to make their applications to the hospitals by November 1st. They submit to the Canadian Intern Board, on the same date, the names of all hospitals to which application has been made, arranged *in order of preference*. The hospitals, in turn, send to the C.I.B., by December the 1st, a list of those applicants who are their first choice and a list of alternates.

The C.I.B. then dovetails these together, giving each hospital and each student their first choices whenever possible. No student is allocated to a hospital other than his choice, and no hospital is assigned an intern not acceptable as first choice or alternate. This is done during December, following which the names of any students not assigned are sent to hospitals with incomplete quotas, and vice versa.

The Canadian Intern Board is made up of two representatives of the C.A.M.S.I., Dr. Fred A. Logan, assistant superintendent medical of the Toronto General Hospital, Mr. William Kerr, secretary of the C.A.M.S.I., and a representative of the Canadian Hospital Council, Dr. Ansley Seymour, assistant superintendent of the Vancouver General Hospital.

Observations

From reports received the senior students would appear to be very well pleased. Many expressed relief over being able to get this worry of internship off their minds by the New Year. All but sixteen of the students were allocated at once, and almost all of the others have since found hospital positions for the coming year. Reports from the medical student bodies indicate a strong desire to have the plan continued.

As for the hospitals it would appear that the majority are definitely pleased. As one administrator remarked, "Never before have we had our intern appointments practically settled by the New Year". Both teaching and non-teaching hospitals have reported a good roster of interns. In previous years the teaching hospitals, taken as a whole, have had a little better choice; the distribution would not seem to have been affected one way or the other by the changed method. There would seem to have been fewer men make application to hospitals in the United States. This, however, may have been due to the war situation, although the present method of appointment would tend to encourage the taking of an internship in Canada.

Some Difficulties Experienced

It would not be correct, however, to state that no difficulties have arisen. While not numerous, they did occur, and were of two categories: inability on the part of certain hospitals to obtain a full quota and the allocation of interns to hospitals other than those with which they had made private agreements. The latter group of difficulties arose entirely from misinterpretation by hospitals and students of the basis of the plan, lack of co-operation or, in a few instances, to carelessness on the part of individual students. This group of difficulties is not intrinsic to the plan and should be minimized next year.

Requiring more consideration, however, is the viewpoint expressed in two hospitals, at least, that they have not fared as well under this plan. Although perhaps more interns than usual were placed in Canada this year, some hospitals did not fare as well as they thought they should. Certainly some hospitals had to draw more heavily on their alternate list of choices than hitherto. This did not necessarily mean that some other hospitals were getting the preference. The more likely explanation was that, as students are yearly applying to a wider range of hospitals, a number of hospitals received routine applications from many good men who otherwise would not have applied. Obviously the upper bracket students were accepted in several hospitals. Where students are accepted in several hospitals they will finally select the hospital of their choice irrespective of the existence of the C.I.B. and, sad to relate, often irrespective of any previous contract, either.

It is probable that some hospitals by signing men up early might have succeeded in retaining certain students of their choice through the mid-winter shuffle. But one must bear in mind that the majority of the non-teaching hospitals have seldom been able to complete their quota in the past few years, and the difficulty is increasing. Some hospitals sign up interns very early—in the previous October—and then, in the late winter or spring, find many of their appointees, accepted in other hospitals, sending in their regrets. Under the

old system many hospitals could never be sure that their early appointees would turn up. With each year, too, more internships are available and each year the shortage is becoming more noticeable. The war may wreck some intern schedules completely.

Failure to Indicate Preferences

Difficulty arose, too, where students failed to give the C.I.B. their list of hospitals in order of preference. In one case the student is said to have used considerable effort and influence in seeking appointment at hospitals in two different cities. Both accepted him. But he failed to state his preference. When the C.I.B. allocated him to the hospital to which the evidence indicated he wished to go, the fat was in the fire, and the Intern Board received criticism for a situation entirely due to the student's failure to co-operate.

Advance Private Contracts

Several times students, despite having submitted a list, signed "contracts" with hospitals before the date set for the consideration of applications by the C.I.B. and *failed to notify the Board.* No harm was done if this hospital were the first on the student's list, or if it were the only hospital to which he had applied, but several times the hospital was not first on his list and he was accepted later at a hospital rated *higher on his preference list.* Not having been informed of such contract, the Intern Board naturally assigned him to the higher listed hospital. Such lack of good faith must be discontinued if the plan is to succeed.

Some confusion was caused, too, by one hospital writing in advance to applicants whom they desired to accept asking that they sign a contract within so many days. To guarantee some appointment at least, a number signed such, but apparently were prepared to ignore it if a preferred hospital accepted them. Another intern committee, not realizing the awkward position created, asked applicants at a personal interview if that hospital were their first choice. Naturally the quick thinkers all said "yes"—with their fingers crossed or other mental reservations. Unfortunately the net tendency is to weaken the student respect for pledges.

Apple blossom time in the Annapolis Valley.

In a few instances the hospital, on receiving word of the allocations from the Intern Board, overlooked sending an official notification to the students. This caused some needless anxiety.

Conclusions

The results of the first year's operation would appear to be definitely favourable. For the students it was distinctly so; for the hospitals, the experience, with certain exceptions, seemed quite satisfactory.

The allocations were absolutely impartial. Great care was taken to safeguard this point. The Board members deserve hearty commendation for their sincere and faithful efforts to evolve a workable plan.

Non-teaching hospitals, including those at some distance from teaching centres, would seem to have received average quotas. There is no adequate evidence to indicate that the plan discriminates against the non-teaching hospital.

Practically every difficulty experienced was due to lack of co-operation or misunderstanding on the part of either the students or the hospitals. This should be minimized next year.

Ample alternate acceptance lists should be made out by the hospitals. The average hospital will not get as many first choices because each year more students are applying to a wider range of hospitals.

It is absolutely imperative that students and hospitals participating follow the simple requirements of the C.I.B.

The plan should be considered as still in the experimental stage. Suggestions for improvement would be welcomed, we are sure, by the Canadian Intern Board. In view of the opinions received to date, it is anticipated that the plan will be put into operation again this coming autumn.

School of Nursing of the Montreal General Hospital *looks back to the "Horse and Buggy Days"*

IT was in 1890 that Gertrude Livingston arrived in Montreal with two young New York graduate nurses to found a school of nursing at the Montreal General Hospital. No pioneer spirit could have asked for a better opportunity. She found the nursing service (for the previous twelve years under a lay matron) in a disorganized and wholly deplorable state. A system of "free nurses" prevailed at the time. The nurses signed no agreement and could leave on a month's notice. At the end of a year at the hospital they were allowed the black velvet ribbon on the cap, were called "head nurses" and were paid $8 a month. However, no formal recognition, such as credentials, was given when they left the hospital. With such a slipshod system of "training" it was no wonder that the patients suffered.

The sick lay on straw mattresses which rested on a framework of unpainted iron pipes. No attempt was made to keep a record of the patient's condition, no medicine lists were kept; the patient helped himself to medicine from the bottle which stood between his soap and tobacco on a shelf behind his bed. In the children's ward a curtain drawn across one portion of the ward was the only concession made to isolation technique for diptheria cases. If patients were delirious they were strapped in their beds while the nurses slept during their "off duty" hours.

There was, too, a lack of system in the non-nursing services which could not but be painfully obvious to the most casual visitor. One of the favourite spots for drying bed linen was the main staircase of the front portion of the hospital. A huge stove in the front hall comprised the heating system, said stove being minus three legs and valiantly propped up by small piles of bricks.

Back in 1875 when the hospital was then fifty-six years old, an attempt had been made to establish a school of nursing through the influence of Florence Nightingale. This, however, was not successful. It was reported that Miss Nightingale's nominee "had a distinctly fascinating personality and had much force of character, but was very dictatorial and lacked tact. There was endless friction until her resignation three years later".

The Transition

Under Miss Livingston's regime there were swift and sweeping changes, among the first being a supply of mattresses and quilts for patients. Chart boards for each bed, medicine lists, reports and orders became routine. Adequate isolation was provided for infectious cases and proper nursing care was made available during both night and day.

The changes which were made during the first year of Miss Livingston's superior tendency had made a striking difference in the work of the personnel and in the appearance of the whole hospital. The Governors paid eloquent and grateful tribute to her for this transition.

"Since the day of its foundation, the old Montreal General Hospital has never been in such an efficient condition. Within the last 12 months changes have occurred here and there which give the impression that the venerable institution has aroused from its Rip Van Winkle condition and wishes to show that it has merely been drowsy, and is not yet moribund. The Outdoor Department has been greatly enlarged and extended. The nurses' old quarters on St. Dominique Street have been converted into rooms for the use of specialists and others.

"In the wards great changes are observable, they are cleaner, brighter and have a more business-like appearance than they ever had before.

"The nurses appeared in the new Montreal General Hospital uniform for the first time on Sunday, June 22, a composition of pink and white gown with a neat cap and badge, all aesthetic and antiseptic(!). The house staff are turned out in white patrol jackets, and everything is as

Left: The first graduates of the Montreal General Hospital School for Nurses. Miss Gertrude Livingston, founder of the school is shown in the centre. Dr. R. C. Kirpatrick, one of the attending physicians, is also shown.

Right: An operation in progress at the Montreal General Hospital in 1892. Dr. Chas. F. Martin, emeritus dean of the faculty of medicine of McGill University, is in the foreground at the left, and the doctor at the right is the late Dr. R. Tait Mackenzie, the famous sculptor. The third doctor is Dr. Harvey Smith, of Winnipeg.

Opposite page: This "two horse power" ambulance was used by the M.G.H. as recently as the "twenties".

spick and span as on a battleship."

In 1896 the first diet kitchen was opened in the hospital and a year later Miss Gracie Livingston, sister of the superintendent, was appointed dietitian. It was through Miss Livingston's efforts that funds were raised to build the Jubilee Nurses' Home, the cornerstone of which was laid in 1897 by Lord Lister.

During her thirty years at the Montreal General Hospital Miss Livingston's work was an inspiration and an example for other nurse administrators. To her goes the credit for the first "preliminary" class in Canada, the first probationer's uniform in Canada, and the first three-year training course in America. She also fought for and secured for her school the first full-time instructor for nursing schools in Canada.

She has had two worthy successors, Miss S. E. Young, superintendent until her death in 1927, and Miss M. K. Holt, the present superintendent. It was proudly pointed out during the ceremonies which marked the silver Jubilee of the Training School in February last, that with 1,616 nurses on the graduate roll call, a member of the *first* graduating class of 1891 was at that very time "on duty".

Chicago Institute for Administrators to be Held in September

The eighth annual Institute for Hospital Administrators, sponsored by the American Hospital Association, will be held at Judson Court of the University of Chicago, commencing Wednesday, August 28th and continued through to September 11th. The Institute, which has the support of the American College of Hospital Administrators, the American College of Surgeons, the American Medical Association and other bodies, will be completed in time to permit attendance at the convention of the American Hospital Association and other organizations convening concurrently in Boston. The Institute will be directed by Dr. Malcolm T. MacEachern, assisted by Arnold F. Emch, and Mr. Gerhard Hartman.

An intensive course of lectures, group conferences, demonstrations and round table discussions has been arranged. As in previous years, the mornings will be devoted to seminars and lectures at the University, the afternoons to group conferences and to demonstrations to divided groups at various Chicago hospitals. This Institute is conducted with the co-operation of the leading Chicago hospitals and includes in its lecturers and collaborators the outstanding experts in the various fields of hospital activity in Chicago.

A number of guest lecturers will be present to give special lectures and to assist in the round table conferences. These include the following:

Benjamin W. Black, M.D., Oakland, Cal.
Frank R. Bradley, M.D., St. Louis.
Robin C. Buerki, M.D., Chicago.
Fred G. Carter, M.D., Cleveland.
Arkell B. Cook, Ann Arbor.
Margaret Harrington, Detroit.
Rev. Sister Henrietta, R.N., New Orleans.
Clara M. Konrad, R.N., Jersey City.
William V. Morgenstern, Chicago.
Joseph G. Norby, Milwaukee.
Stanley J. Seeger, M.D., Milwaukee.
C. Rufus Rorem, Ph.D., Chicago.
William H. Spencer, Chicago.
Jewell W. Thrasher, R.N., Dothan, Alabama.
Harvey Agnew, M.D., Toronto.

The Sick Nurse

HELEN S. PETERS, R.N., Superintendent of Nurses, University of Alberta Hospital, Edmonton

THIS subject can be considered from three angles:

1. How can we best insure the admission of only healthy students to the schools of nursing?

2. What preventive measures can we take to guard against illness?

3. What are the chief illnesses from which nurses in hospitals suffer?

The subject will be considered from the standpoint of the student nurse, as it is there that the foundations are laid upon which the health of the graduate nurse will be built. If the student leaves the school with a good understanding of her health requirements, she will probably maintain such in her graduate work.

The Admission Check-up

How do the schools of nursing find out whether the applicant is in good physical condition? Usually a form is sent out to the student, to be filled in by her doctor and returned. Her doctor may, and probably will, give her a thorough examination at that time, but there is the possibility that he has known her all her life, is quite sure she is "in good physical condition", and so fills in the report without careful examination. In either case the facilities for special examinations may be limited, moreover the form is given to the applicant herself, who then knows exactly what report her doctor has made of her condition. There is the possibility that an unfavourable report might cause a good deal of unpleasantness in a small community.

In our hospital we have tried to overcome these difficulties in the following way:

When the application forms are sent out a "Statement of Physician" is also sent, to be returned to us with the other forms, and the applicant is told that when her application is being finally considered she must come to the hospital for another physical examination.

If this first report shows any serious trouble, she is notified that she cannot be further considered and she can then make other plans. This prevents loss of time and unnecessary waiting on her part. If she has some slight disability, she is advised to consult her doctor regarding treatment; the disability will probably be cured before she is next examined.

When a class is to be enrolled, all those whose applications are complete and satisfactory in every other way are written to and told that they must come to the hospital within a certain time. On arrival they have their chests x-rayed, complete blood counts, urinalysis, and Mantoux tests done. When these reports are available, applicants are given a careful physical examination by the medical superintendent, or some doctor whom he may ask to do it, and referred to specialists for any further tests or examinations which he thinks indicated. Any applicant whose tonsils have not been enucleated is told that if she is accepted she must have them removed before she enters. Final choice of students is then made.

Preventive Measures

As soon as the students are admitted the preventive measures are begun. Schick tests and Dick tests are done, and diphtheria toxoid and scarlet fever serum given as indicated. Typhoid innoculation is given, and Mantoux tests are repeated on all those whose previous tests were negative. (Smallpox vaccination is required within two years prior to admission.)

During the three years of training the following routine is carried out:

Mantoux tests are repeated at intervals of 4-5 months unless they are positive. Chests are x-rayed and a complete physical examination is carried out once a year in the month in which the student's birthday occurs. Should there be any reason for so doing, more frequent examinations are given, and any defect found in routine examinations is referred to a specialist for treatment.

Students' weights are checked every month and cod liver oil and ultra violet ray treatments given every fall when indicated. Typhoid inoculation is repeated at the end of the second year.

The importance of health measures is stressed at every possible opportunity during the teaching program and students are urged to enter into every outdoor activity available. They are told where there are facilities for tennis, riding, skating, skiing, hiking, all within very short distances of the hospital.

Common Illnesses

In spite of these efforts illnesses do occur amongst students and we come to our third question, What are the chief illnesses from which nurses in hospitals suffer?

From the figures at our disposal, it is apparent that diseases of the upper respiratory tract head the list by a large majortiy. Last year, the first in which all new students had their tonsils out prior to admission, we reduced the number of days lost from this cause by 120 as compared with the year before. This year and next, after which there will be no students in the school who are likely to develop tonsillitis or to require the removal of their tonsils, we hope to further reduce this number. Furthermore, there will be no time lost because of tonsillectomies.

Communicable diseases take a large toll—although this varies greatly according to the number of these dis-

From an address given at the annual convention of the Alberta Hospital Association, Edmonton, 1939.

—Courtesy Dr. J. Moss Beeler, Grady Hospital, Atlanta, Ga.

"Hour by hour, the long night through,
The nurse on nightwatch keeps her faith."

eases prevalent in the city. In this school there were 373 days lost from communicable diseases in the year ending March 31, 1938, and only 65 days in the year ending March 31, 1939.

Important factors in preventing the spread of communicable diseases amongst nurses are: (1) the giving of the necessary vaccines or sera, (2) strict isolation for at least 10 days of all children admitted to hospital and of any nurse who may develop any of the symptoms of these diseases, and (3) early diagnosis.

As for tuberculosis among nurses, one would like to stress the importance of protecting the nurses by examining the sputum of all patients with a cough, even though they may have been admitted for other reasons.

Infected fingers, boils, and other infections are prominent on the sick list, and students should be taught the importance of requesting care at the earliest sign of infection. As these are most prevalent in the fall and winter months the need of keeping the resistance up in every way possible should be stressed.

Appendicitis seems to be something that we cannot do anything to prevent, but we can encourage early reporting of symptoms, thus effecting early diagnosis with operation, and so lessening the danger. Adequate time off before returning to duty is important so that the students may not have a lowered resistance and so be liable to develop other trouble.

Foot strain appears to be decreasing in recent years—probably because the girls of the present generation take more part in athletics and also because the laity has become more conscious of the necessity for wearing more suitable and better fitted shoes.

On completion of her training, the student should be given another careful examination, with tests for any defects which may have been observed or have required treatment during that period.

With the prominence now being given to health teaching and preventive medicine, it is very important that the first approach in schools of nursing should be the health of the student herself, so that she may be able to pass this knowledge on to her patients both by example and by teaching. There is, however, some danger that, with so much emphasis being placed on health, students may tend to become over anxious regarding their symptoms, real or imaginary. For this reason very wise and careful teaching of health is required.

Excellent Seminars Being Held in Psychiatric Hospital

The psychiatric seminars being held every Saturday morning at the Toronto Psychiatric Hospital provide an excellent means of keeping up with the latest developments for those interested in psychiatric care and in patient psychology. For several years now the Ontario Department of Health has sponsored these seminars at this hospital and each week some local or guest authority on one of the many aspects of psychiatry and mental hygiene speaks or demonstrates on a selected subject. These talks are open to medical and hospital persons interested in this field.

Securing and Maintaining Adequate and Competent Personnel in the Small Hospital

HELEN L. POTTS, R.N.
Woodstock (Ont.) General Hospital

THE securing of competent personnel is the definite responsibility of the hospital administrator. In some of the large institutions a "Personnel Director" has complete charge of employment, but in the majority of smaller hospitals this is the sole responsibility of the administrator, who must select, direct, supervise, and maintain the morale of, the workers. Too frequently the administrator is handicapped by financial factors in this responsibility.

Of first importance is the employment of qualified, responsible people who are willing to assume leadership in the departments for which they are selected. These heads or key persons must be well trained and able to adjust themselves to new situations and learn new ways. They must be able to direct and teach others, and to work without friction with their associates. Above all, they must show keen interest in the task at hand and evince a spirit of co-operation. Care and judgment must be used in the selection of personnel, and thought and study put into the planning and outlining of the duties for which each must be held responsible. Having secured the right people to carry responsibility, the administrator must then see that working conditions and surroundings are such as will encourage the employee to put forth his best efforts, and bring him such satisfaction and happiness that he will be content to remain in the employ of the institution for an indefinite period.

Job Analysis Required

An adequate study of every piece of work in the institution must be made by the administrator, so that she may know what that work and requirements demand of the person who is to handle it. Salary allowance must also be studied, taking into consideration salaries paid for like work in other departments, institutions or businesses within the community. Salaries must be in line with the requirements of the work and sufficient to attract the right type of person. If maintenance is to be included with salary allowance, a review of maintenance provisions must be made. Comfort of living quarters, quality of food served, quantity of laundry allowed, provision or non-provision of uniforms must be considered, and replacement allowance, if such be made. Hours of work must be outlined, and off-duty periods made definite. When possible a schedule should be made out which may be followed with the least interruption to routine, yet permit the employee to plan in advance for recreation periods.

Evaluating Applications

Knowing the work and the specifications for each type of work, the administrator is then well prepared to interview applicants. Where possible a personal interview is best. This gives an opportunity to study the applicant from the standpoint of personal appearance, general manner and personality. Coupled with a consideration of the education, special preparation, training, experience, and other assets, one has a good composite picture of qualifications of the applicant for the position.

Good Morale Essential

The promotion of good morale is a vital consideration. To hold competent personnel, good discipline must be maintained. A kindly, considerate and understanding manner in handling the various problems that arise will help considerably in the creation of a co-operative and loyal spirit. The discipline and spirit pervading any group of people will be in direct ratio to the spirit demonstrated by those in higher authority.

To meet the employees' viewpoint, it is essential that group conferences be held. The employee will respond readily to fair dealing. He should have a complete understanding of the part he plays in the function of the hospital, and should realize that careful performance of his duties will contribute to the benefit of the patient. His duties and responsibilities must be definitely outlined, his hours regulated, his salary or wages in keeping with the service rendered. Each employee should know what he may expect in vacation allowance, or in case of illness—time allowed with full, or part pay and amount of hospitalization or medical care provided. The employees' health programme should be explained and accident prevention encouraged. A system of salary increase should be inaugurated and merit for faithful service sustained.

The Combination of Duties

The average small hospital presents personnel problems quite different from those in the larger institutions. It becomes very necessary to combine the work of two or more departments. This requires the employment of department heads with training and capabilities to handle several activities.

This combination of duties may vary in different hospitals. The business office may handle the bookkeeping and clerical work, information and telephone service, and the admitting of patients very satisfactorily; the record librarian's work and the admission of patients can be a com-

(Continued on page 44)

From an address given at the Hospitalization Conference of the American College of Surgeons' Sectional Meeting, Detroit, April, 1940.

Training in Hospital Administration

By G. H. A.

HOSPITAL administration is to-day a most exacting profession. No longer is it a vocation wherein anyone without previous knowledge or training can expect to become a success. This is largely because of the remarkable development of hospital work and the almost terrifying complexity of the scientific side of medicine.

The administrator must have a knowledge of general business principles, of accounting, of purchasing and market trends, of tests for values, of the art of bargaining, of the chemistry of laundry work and of the restaurant business. He must be somewhat of a plumber and an electrical engineer. He should be a pedagogue. Not only must he have a general knowledge of scientific medicine, but he is expected to have an almost uncanny knowledge of the *art* of medicine and the psychology of medical men. He must understand the principles of social science. He must be somewhat of a politician. Above all, he must be a leader of men and women, one who can handle his personnel and who can meet the public and gain their support.

Few indeed are the tasks requiring so many and varied qualifications. It would be discouraging were it not at the same time so fascinating and stimulating to realize the scope of the knowledge expected of the administrator of to-day.

Better Training Essential

It is now generally realized that the prevailing haphazard method of preparation is utterly inadequate to meet present day requirements. Until very recently at least practically the only method of gaining previous experience was by the "apprenticeship" method. Unfortunately in most instances this was seldom a true apprenticeship, for all too often the junior received practically all of his training in one department only and had little opportunity of getting other than sketchy glimpses of the work of other departments. Those ultimately becoming administrators seldom began their careers with that as their objective.

Obviously the time has come when we should have, in every major country, facilities for the proper training of administrators. Practical experience will always be necessary, but academic training in the many subjects of concern to the administrator is increasingly essential. To quote Dr. F. G. Carter of Cleveland, "a combination of the academic and the apprenticeship types of approach will prove most satisfactory in the long run as a preparation for the work in hospitals". This means not only the establishment of special courses, but the development also of better apprenticeships.

Present Facilities for Training in Administration

What are the existing facilities for administrative training in our various countries?

The International Hospital Association

The International Hospital Association itself has done a great deal to further training in administration. In the alternate years, between the biennial Congresses, organized tours have been conducted in several European centres—in Frankfort (1932), in Zurich (1934) and in Czechoslovkia (1936).

Great Britain. In Great Britain commendable steps have been taken to set up standards for certification, but not a great deal has been done as yet to provide organized training in the subjects under examination. The Corporation of Certified Secretaries gives examinations twice a year (June and December) in hospital administration. This body, incorporated in 1923, provides a central organization for secretaries and administrative officials in many other types of activity than hospital administration, the examinations being held in the respective subjects. There is a preliminary examination in basic subjects, followed by an intermediate examin-

From an address prepared for the International Hospital Congress, cancelled by the outbreak of war.

M.S. "Columbia" on Patrol

For thirty years the stalwart "Columbia", the hospital ship of the Columbia Coast Mission, has made her way up and down the British Columbia coast. Last year her mileage on medical patrol was 17,034, and of this 3,874 miles were travelled in answer to radio "S.O.S." calls. Dr. Gordon Worsley, the ship doctor, saw 436 patients in their homes, and 446 patients came to the ship's dispensary for consultation or treatment. St. George's Hospital at Alert Bay, two hundred miles up the coast from Vancouver, is the home port of the "Columbia" and she reports there once a week, when surgical cases are cared for.

ation in hospital secretarial practice, hospital accountancy, hospital law, mercantile law, economics and in hospital organization and management. The final examination covers advanced phases of the same subjects. Being an examining body, the Corporation does not endeavour to provide the candidates with the required training. Examinations are held as far away as India.

Fellows or Associates are known as "certified secretaries" and are entitled to the qualifying letters F.C.C.S. or A.C.C.S. At the present time there are quite a number of Fellows and Associates, who have taken the degree in hospital administration.

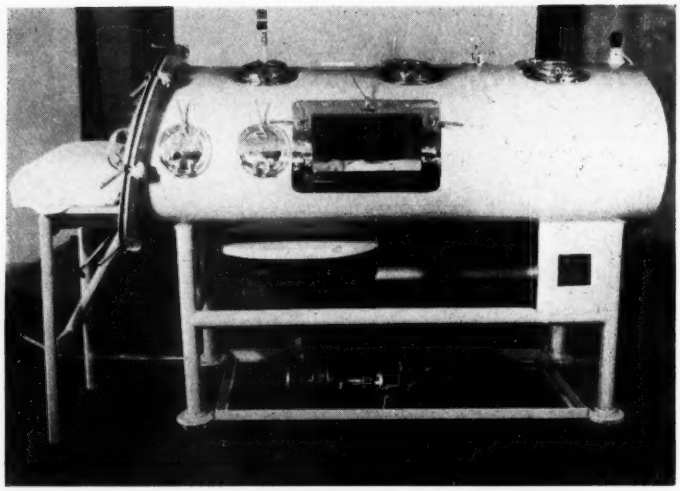
Furthermore, as a result of the Corporation's endeavours, the London County Council has introduced comprehensive evening courses in hospital administration leading to the C.C.S. examinations. Two correspondence schools have also prepared courses of study suitable for those desiring to take the C.C.S. examinations.

The Incorporated Association of Hospital Officers in Great Britain has recently decided that its educational requirements will be raised and a much more intensive type of examination set. A postal tutorial scheme has been created to provide by correspondence necessary tutorial help to the candidates. There are intermediate and final examinations leading to the Fellowship (F.H.O.A.) or the Associate membership (A.H.O.A.). There are now about 200 Fellows and approximately the same number of Associates in the I.A.H.O. The program is under the direction of a Director of Education.

Prior to this development the I.A.H.O. had recommended to the Voluntary Hospitals Commission (Sankey) that an Institute of Hospital Administration be set up. This was supported in the Sankey report.

Certain short refresher courses have been held in England, as, for instance, the course for junior hospital officers at Birmingham and the one at Liverpool.

Eire. No organized system for special training exists here. A limited number have become Fellows of the Corporation of Certified Secretaries. One stumbling block here, as in many other countries, is that so many hospital boards look upon the Registrar or Secretary as a superior clerk rather than as the chief executive officer.



Jewish General Hospital, Montreal, Builds its own Respiratory Apparatus

This fine "iron lung" was built by the engineering staff of the Jewish General Hospital in Montreal. Efficient in operation it is a tribute to the skill of those who made it.

France. Beyond the assistance given by the hospital journals and the hospital conventions, no facilities for training administrators exist. Various university centres do have schools on governmental or communal administration which may be attended by candidates for, or incumbents of, hospital offices.

Germany. No special training courses are available. Administrators are often recruited from officials in other fields. However, much is done to keep administrators abreast of current developments through the Association for Administrators of German Hospitals, Health and Nursing Institutes; through the hospital associations, and by inspection tours.

Hungary. For several years the Hungarian Clinic and Hospital Association has been giving formal training to hospital administrators. The course is given in Budapest and is limited to 50 students. There is first a twelve-month period of practical work in various designated institutional departments. This is then followed by an intensive three-months' lecture course comprising some 350 hours of lectures on various technical and other phases of administration. Since 1935 systematic short courses have been given also at the Institute of Dietetics in Budapest. In 1937 a congress was held in Debreczen and in 1938 a study tour in the west.

Switzerland. No organized training is given other than through short courses. Some administrators have had training elsewhere.

Chile. In South America, much progress has been made in Chile. In 1935 the Association Chilena de Asistencia Social sponsored an Institute in Hospital Administration in Santiago. As a result the University of Chile established two courses of hospital administration, one for the directors of larger hospitals and another for the training of graduate nurses to administer small hospitals and dispensaries.

Australia. No plan of training is yet in operation, but in Victoria a committee is now actively engaged in preparing a syllabus of training based in part on that of the Hospital Officers' Association of England.

Canada. Canadian hospital leaders have been closely linked with the United States in the program outlined below. Four of the Universities (Toronto, McGill, British Columbia and Western Ontario) have graduate courses in hospital supervision, including administration, for nurses, but the instruction in administrative detail is very limited. In addition, a three-week "refresher" course in hospital administration for nurse admin-

istrators is being given at the University of Toronto, sponsored by the University of Toronto School of Nursing.

United States of America. Tremendous progress has been made in the United States during the past few years. In this the American Hospital Association and the American College of Surgeons have been invaluable pioneer contributors, but the greatest stimulus to this movement during the past few years has been the American College of Hospital Administrators, a degree conferring body, representing the United States and Canada, which now comprises 30 Honorary Fellows, 303 Fellows, 375 Members and 131 Associate Members.

Two types of courses have been developed. Realizing that for many years most of our administrators will continue to come up from the ranks, well organized short "institutes", of from two to three weeks have been held. The best known one, that held in the University of Chicago and directed by the above three organizations, is now in its seventh year.

Others have been inaugurated by the American College of Hospital Administrators, in co-operation with various universities and state hospital associations. Among these are the Minnesota Institute at the University of Minnesota, the New York Institute at Columbia University, the Southern Institute at Duke University, the Western Institute at Stanford University, and the New England Institute at Harvard University.

An evening session course in hospital administration is also being conducted at the University of Chicago in co-operation with the American College of Hospital Administrators. This course meets two evenings a week, one evening being devoted to lectures by a corps of outstanding administrators and the other evening being a seminar conducted by one of the three continuing lecturers.

Longer courses, undergraduate and graduate, have been set up by various universities. The University of Chicago has had a one-year course plus internship for several years. There is a four-year combined apprenticeship and university course at Antioch College. The University of Pittsburgh has a three to four-year course for graduate nurses leading to

(Continued on page 46)

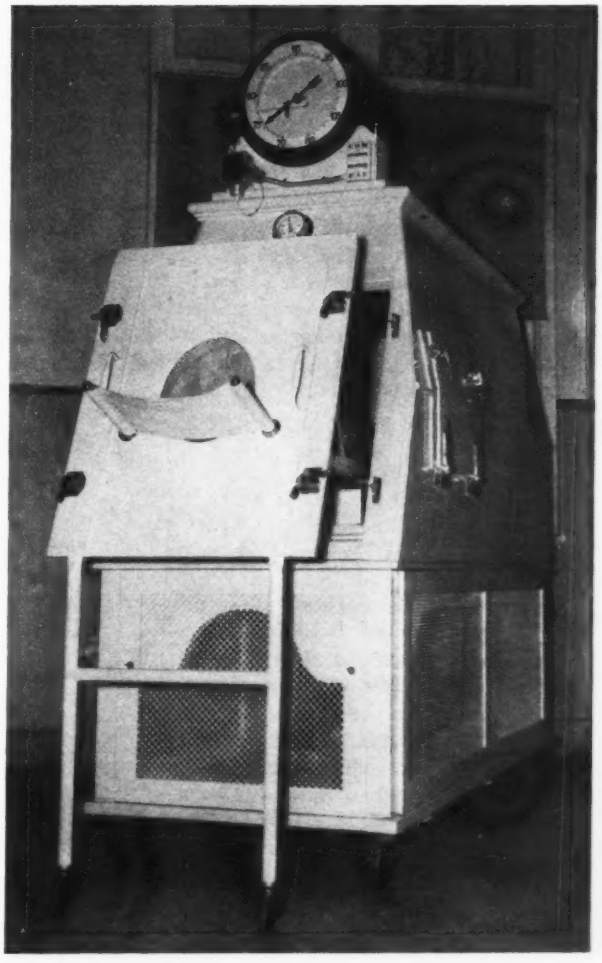
Unique Cancer Refrigeration Unit Built in Toronto General Hospital

THE ingenuity of hospital engineers in Canada has again been demonstrated by the construction at the Toronto General Hospital of a very ingenious cabinet for the refrigeration treatment of patients suffering from malignancy. During the past year research has been conducted in several centres on the value of refrigeration of patients by means of wet and dry ice packs.

Mr. C. J. Decker, administrator of the hospital, conceived the idea of a thermostatically controlled electrically operated cabinet somewhat similar in appearance to the iron lungs used for other conditions. Mr. Albert Darbyshire, the chief engineer of the hospital, drew up the plans for such a cabinet and constructed it at a cost of approxmately $1,600. This cabinet, which scientifically controls the refrigeration of the patient, is said to be the only one of its kind in operation.

After receiving a sedative, the patient is placed in the machine, the electric refrigeration started and the patient's body temperature gradually reduced to between 83 and 88 degrees. To accomplish this, the temperature in the cabinet is lowered to about 40 degrees, although it could be reduced still lower. During the 72 hours that the patient remains in the cabinet in a state of coma, the blood pressure is taken regularly through portholes and the patient is fed through the nose. A meter records the temperature of the cabinet at all times, and a graph registers the temperature of the patient. The whole apparatus is automatically controlled.

It is emphasized that this refrigeration treatment does not cure cancer. It does, however, relieve the pain for a considerable period of time and for that reason has definite value. It is anticipated that this unit will be used for research on the efficacy of this treatment in other conditions.



—Courtesy of Toronto Evening Telegram, 1940.

Obiter Dicta

Sales Tax Exemption

AT the forthcoming session of Parliament it is anticipated that our legislators will again face the task of devising new ways of raising money to meet the staggering cost of the war, a cost that is now said to be a million dollars a day and that will possibly be doubled within a year. Financial experts at Ottawa are now combing over every possible source of revenue and are checking and re-checking for any leaks in the present taxation.

Since the inception of the sales tax enactment, our public hospitals have been given exemption from its provisions. What this has meant to our hospitals has never been accurately worked out, but we do know that it has permitted hospitals to carry on which otherwise could not possibly have remained solvent and that, being non-profit institutions, every cent thus saved has been ploughed back into service, either in the form of increased services to patients or added facilities for their care. Rumor has it that among the items now under review at Ottawa are the sales tax exemptions. It would be literally a calamity for the great majority of our hospitals if this exemption were lost. While there has been no direct suggestion that the hospital exemption is in jeopardy, members of the various boards of governors and of the medical staffs would be well advised to keep a watchful eye on developments in order that the preservation of this very vital exemption be safeguarded.

The Refugee Physician

AGAIN this question of regugee physicians has been brought into prominence, this time by a columnist for a widely circulated eastern daily who has endeavoured to inflame her readers by creating the impression that the medical profession has deliberately endeavoured to prevent medical care being provided to the many frontier and sparsely settled communities in this country. That she has turned her vitriolitic pen against the Canadian Medical Association, which actually has nothing to do with the licensing of physicians, matters little to those who simply must vent their spleen against someone. Everyone is deeply sympathetic over the plight of these refugees and is anxious to have as many placed here as the country can absorb. Unfortunately, however, some of our people have allowed their sentiment and enthusiasm to outweigh sound judgment and have confused questions at issue.

Medical care for outlying districts is an example in point. There are a number of rural communities urgently requesting a medical man. The medical associations are glad to keep a file of these places and have placed many men. But some places cannot get a doctor and have appealed to the refugee committees. Refugee doctors state that they are willing to go to some of these places. Then those villainous dogs in the manger, the medical licensing bodies, who will not send Canadian doctors, refuse to let in European doctors either. Political pressure is then put on the government to threaten the doctors if they don't give these refugees a license to practise. This is the side the public gets.

But that is only part of the story. Several very vital considerations should be borne in mind:

1. When a physician is given a licence to practise he can go *anywhere* in that province. Sad experience has revealed both in Canada and in the United States that refugee physicians quickly gravitate to the big cities, where there is already a surplus of doctors.

2. If a rural community in Canada has not got a doctor it is almost always because that community cannot support a doctor. Our Canadian graduates are constantly seeking locations where they can make a living. *The use of refugee physicians will never solve the problem of medical care in sparsely settled or dried out areas.* That is a red herring drawn across the trail. Most of these communities can only get adequate care by means of outside assistance, possibly by governmental subsidies.

3. At the present time lack of opportunity to make a living requires an altogether too high percentage of our medical graduates to leave Canada—a distinct financial and citizenship loss to this country. Sympathetic though we are to refugee physicians as a whole, and particularly to individuals, we must face the fact that, in a saturated field like medicine, every foreign doctor admitted will require one more of our own Canadian graduates to leave his native country.

4. The admission of research workers is a different matter. They are welcome and a number are already doing excellent work in research laboratories. The same might be said of some of those in highly specialized fields.

5. It is a common weakness of uninformed writers in the lay press to berate medical licensing bodies, to call them tyrannical trades unions and other epithets.

They do not seem to realize that these bodies have been set up to *protect* the public, not the profession. Anyone, provided he has the adequate training and an ethical reputation, can take and pass these examinations. Unfortunately, medical schools in Europe are not standardized as they have been on this continent. There is a wide divergence in the quality of the training and in the ethical practices of European graduates. Indiscriminate lowering of the bars would be disastrous to the sick in this country.

If the government were willing to assist these doctors to live in these areas and were prepared to make arrangements whereby their licence to practice could be limited to such areas only, the situation would be considerably clarified. In view of present conditions, however, considered action, not hasty judgment, is in order.

Daylight on the Nomenclature Problem

IT would appear that the long-existent confusion over nomenclatures will be settled in the near future. For years hospitals have been improving their systems of clinical records, installing record departments and expert record librarians, building up medical staff enthusiasm for records, perfecting forms, and creating higher standards for the qualification of librarians. But always has remained that confusion of terminology and nomenclature. Interns come with pre-conceived usages of terms from their medical schools and each new text book, or monograph or journal article coins a few more words. Several nomenclatures have received wide acceptance and, to add to the difficulty, some of the larger hospitals have so modified other systems that they have practically a system of their own. Indeed, in some hospitals different terminologies are insisted upon in different services! All too many hospitals have no official nomenclature.

Of late years the two nomenclatures receiving most support on this continent have been the Alphabetical Nomenclature, developed by Dr. Thos. R. Ponton and the Standard Classified Nomenclature, the product of a joint committee representing a large group of medical and hospital organizations. Both are excellent systems. Recently the Standard nomenclature was taken over by the American Medical Association thus adding to its official recognition. In February, Dr. Ponton and his publishers made a most gracious gesture towards clarifying the situation by offering to discontinue the publication of the Alphabetical system and to co-operate in the proposed 1940 revision of the Standard Nomenclature. Possibly the best points of both systems can be incorporated in this revision.

This announcement, coming on the eve of the Conference on Nomenclature in March, sponsored by the American Medical Association, permitted that conference to devote its session to a discussion of ways and means of revising the Standard system to better meet the needs of research institutions and of the smaller hospitals. The Standard system is now widely used in the larger hospitals but its very completeness has proved discouraging to small places without an expert record librarian. It can be adopted in simplified form now, but further simplification may be developed. In England a joint committee representing three of the largest hospitals recommended its adoption there.

Last autumn the Canadian Hospital Council appointed a special committee on nomenclature to make recommendations respecting a choice of nomenclature and to consider especially the situation in the smaller hospitals. An excellent committee of record librarians and clinicians has been formed under the chairmanship of Mr. Fred J. Fish, director of the records department at the Vancouver General Hospital. These recent developments will simplify the task of this committee, although much still remains to be done before the nomenclature question will be satisfactorily solved in this country.

Graduation

IN many hospitals this will be graduation month. During this month, or perhaps in June, in over two hundred hospitals some three thousand nurses will receive their pin and parchment to the accompaniment of the warm applause of their friends. Graduation day is a great occasion, one of those days in a young woman's life which stands out above all others of her youth and can almost be compared, in the thrill of its anticipation and its glory in retrospect, to her day of marriage.

To these young ladies is extended our heartiest congratulations. It has been a long and arduous course but the goal has been well worthwhile. Maturity comes quickly to the nurse-in-training and she leaves her school with a knowledge, a poise and a conception of life and its responsibilities far different from that with which she entered. Very shortly these young women will be scattered the world over. Some undoubtedly will find a place in the army, an experience which they will never regret. To all go our most sincere well-wishes for a happy and successful career.

And should we not include in our congratulations those who have been responsible for this metamorphosis in these student nurses? The director of the school, her assistants, the instructors, the supervisors, the doctors —all have made their indelible contribution towards the production of that highly-trained, efficient, dependable, kindly and disciplined unit of service, the modern trained nurse. To such unsung moulders of character go also our congratulations.

The Round Table Forum

19. Is it Sound Dictum that "The Best is None too Good"?

John McEachern, Chairman, The Sanatorium Board of Manitoba, Winnipeg, Manitoba.

THE safety of the State, and the efficiency and happiness of its people, can only be maintained by conserving the physical health of the individual citizen who is entitled to the facilities of the best medical science of the day. There is a public demand, as a result of education and publicity for the higher grades of service, that nothing should be withheld which will aid in the treatment of patients, regardless of cost or ability to pay.

Money has been spent generously, even lavishly, in the construction of transportation facilities, erection of public buildings and provision for the unemployed of the community. A small percentage of these expenditures applied to the safeguarding of the National Health would make for a more efficient citizenship, more wide-spread happiness and less unemployment. "Deny yourself, not them."

* * *

Basil C. MacLean, M.D., Director, Strong Memorial Hospital, Rochester, N.Y.

Although the fear has been expressed that hospital care for patients of low income and even of moderate income in the future may have to be kept down to a price, rather than up to a standard, it may be suggested that moderate costs and adequate standards are not incompatible. Most hospital administrators will probably agree that good modern and inclusive hospital care is provided in many good hospitals where there is no exploitation of personnel and where the cost per patient day is not astronomical. In such hospitals, many patients may receive milk instead of cream in their coffee just as they do at home. They receive pharmaceutical rather than proprietary products for medication and they may forego many of the luxuries which have crept into hospital construction and administration during the past two decades especially in the United States.

It is true that progress in medicine has provoked more complex and more costly care in all hospitals and the research or teaching hospital naturally has its special fiscal problems. In the average institution, however, the patient may travel the road to recovery as quickly and as surely in a Chevrolet as in a Cadillac.

The voluntary agency in any field may continue to set the pace, but it will invite an extension of governmental control if it disregards the boundaries of common sense.

* * *

T. W. Walker, M.D., Administrator, Royal Jubilee Hospital, Victoria, B.C.

"Generalizations are apt to be as dangerous as they are tempting"—Lowell.

The dictum—"The best is none too good" is one of the generalizations that has found its way into common usage. It is not literally true. If it were, the Rolls Royce would have a monopoly. "Best" is a comparative term. There is no absolute standard and cost must not be a criterion of quality. The cheapest food is often the best for the individual.

The so called "best" is frequently almost prohibitive in price. For example, stainless steel utensils wear longer than enamelware and do not chip, but they cost four to five times as much. However, enamelware has to be replaced annually. For operating-room uses, stainless steel is probably best because it is the safest.

Hospitals have *beer* incomes and should discourage *champagne* appetites.

Hospital service calls for certain *essentials;* these should be supplied if at all possible. Luxuries should depend on the income.

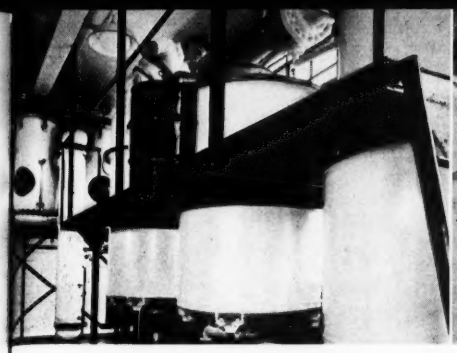
* * *

Reply Received from a Hospital Trustee who Wished to Remain Anonymous.

In many respects we have gone crazy in our fetish for insisting that the best is none too good. We nod our heads in righteous confirmation that the cost is no consideration when it comes to providing for health, when in actual life we violate these principles a thousand times by failing to provide for far more important safeguards in the prevention of disease. Thousands of dollars are invested annually in impressive entrances to hospitals and in providing the latest chrome-plated gadget that the manufacturers have brought out, quite oblivious of the fact that the same money invested in other ways would have more effective and wide-spread effect upon the health of the hospital patients and the people as a whole. I would rather see us give slightly less up-to-the-minute treatment to the few fortunate people who are able to gain admittance to the average hospital and devote that money to extending the hospital services to provide proper care to other groups of patients not now eligible for hospital care in all too many communities.

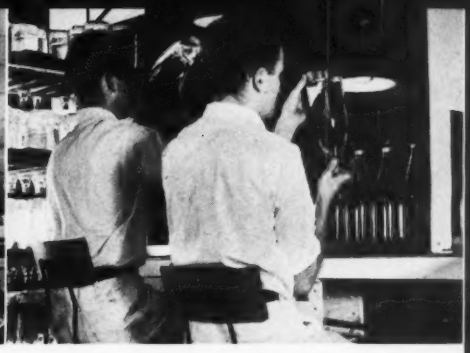
Question for Next Month:

Should We Endeavour to Reduce the Number of Special Diets ?



1. The equipment for the preparation of litre solutions. These tanks are carefully sterilized with live steam as soon as each lot is completed.

2. Air in the litre solution filling room is kept constantly pure by filtration through the oil film.



3. Containers are all inspected individually to discover the presence of any foreign matter.

ABBOTT INTRAVENOUS SOLUTIONS

In litre containers

AFTER extensive investigation and research, the Abbott Laboratories offer the medical profession solutions of the highest standard of quality. This achievement of the Abbott Research Staff now enables hospitals to free themselves of the heavy burden and responsibilities connected with the preparation of bulky intravenous solutions.

Abbott Intravenous Solutions are guaranteed to be STERILE, STABLE and SAFE. They are prepared from chemicals of the highest quality and from chemically pure water. Moreover, they are altogether free from all impurities, including pyrogens.

Representative samples from each manufactured lot of Abbott Intravenous Solutions are tested for sterility by the same critical test which the Government prescribes for biological products. Abbott Solutions are very low in latent acidity and contain no buffers. Preservatives are not used.

Litre Containers

Intravenous solutions are furnished in the Abbott Container, a bottle specially designed to resist high steam pressure sterilization. Its outer protective seal gives positive assurance of sterility. The inner cap is easily removed by the fingers, without danger of contaminating the lip of the bottles. When the cap is removed, there is no inrush of air to carry spores of air-borne bacteria or molds. Moreover, there is no rubber contact with the solution—no "rubber" odor or taste.

New Technique and Equipment

The new and original technique introduced by the Abbott Laboratories has been devised by our Research Staff after several years of experimentation in the largest clinics of this continent. Every detail has been studied in an endeavour to eliminate any loss of time on the part of those who use the Abbott equipment.

Our representative will be very pleased to give a demonstration of the New Abbott Intravenous Solutions and Abbott Equipment.

4. The absence of pyrogenic effect in every lot of Abbott intravenous solutions is demonstrated routinely by intravenous injection of samples of the solutions into rabbits, the rectal temperature of the animal being taken every hour before and after the injections.

5. Following final sterilization, intravenous solutions are again inspected under strong light for foreign particles.

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Ontario Hospital Association News

Group Hospitalization Plans Progressing

AT the last meeting of the Board of Directors of the Ontario Hospital Association, a great forward step was taken in furthering the cause of adequate hospital care to the public of Ontario.

For the last year and a half a special committee has put in a tremendous amount of work in studying Prepaid Hospital Care plans in operation in the United States and Canada, with a view to working out a general plan for the Province of Ontario. Under the chairmanship of Mr. Fraser Armstrong of Kingston the committee is composed of the following members: Mr. A. R. Goldie, Galt; Mr. J. Clark Keith, Windsor; Mr. C. J. Decker, Toronto; Mr. A. J. Swanson, Toronto; Dr. L. C. Fallis, London; Dr. W. J. Dobbie, Toronto; Rev. Father Brennan, London; Sister Madeline of Jesus, Sudbury; Dr. Harvey Agnew; Dr. H. C. Wales representing the Ontario Medical Association, and Dr. Fred W. Routley.

This committee made a very detailed report of the plans which it advocated to the meeting of the Board of Directors. The report suggests in a general way, a plan which can be organized for provincial, under the association, or by communities throughout the province, whereby for very reasonable monthly payments, employees of industry and other groups may secure hospitalization, and whereby the hospitals of the province may be paid the actual cost of this hospitalization out of the funds provided in the plan.

It is probably too early yet to give the details of this plan, as although the report of the committee was unanimously adopted, it was pointed out that further study is required for the perfection of the plan. To this end, the committee was continued and funds were voted for the purpose of securing expert advice in the final perfection of a scheme which it is hoped will prove of great value in Ontario.

—F. W. R.

WOMEN'S HOSPITAL AIDS ASSOCIATION

Province of Ontario

Association formed 1910
Individual Aid formed 1865

Women's Hospital Aids of Mount Sinai Hospital, Toronto

Unique and remunerative achievements have been accomplished by the Women's Hospital Aids to the Mount Sinai Hospital, Toronto.

There are five of these groups, in all, working harmoniously for the hospital and during last year they raised $10,000 for the hospital. One of the achievements during the year was a dinner called a "$10 give or get dinner". This dinner realized $2,000, to establish a fund in memory of the lady who was one of the founders of the Mount Sinai Hospital and auxiliary, Mrs. Slova Greenberg. A gift was also made to the hospital in the form of a wheel chair recognizing the work done during the year, by Mrs. Dorothy Dworkin, President of the Senior Auxiliary.

An interested observer, impressed by the work of the women, presented the ladies with a linen carrier for use in the hospital.

The Sinais Group realized the sum of $3,500 from their Valentine Dance at the Royal York Hotel, Toronto, and from an attractive red heart-shaped brochure which contained goodwill messages and greetings. With this money, they refurnished the interns' quarters and presented the balance of the money to the Hospital Board to help with the deficit.

The Women's Dental and Medical Aids devoted one complete day to holding bridges with refreshments and social time conducted from one home; then theatre nights and a rummage sale. Funds from the foregoing paid for the installation of electric fans throughout the hospital, new flooring for the kitchen and the refurnishing of a number of private rooms.

The Twigs, the junior group, are active in supplying nursery needs. The newly formed group, wives of local pharmacists, are giving unstintingly of their time and energy and promise to become a most active and interested group.

In June, all the auxiliaries joined forces and conducted a three-day street fair and carnival at Alexandra Park. Two children's bands were in attendance. They also had "The Invisible Man", an educational exhibit arranged by the doctors; a ferris wheel, merry-go-round, riding ponies and many other attractions with outdoor restaurants to serve refreshments. Then too, a large supply of daintily boxed food for home consumption had ready sale; one unusual money making scheme being the displaying of advertising banners for various products.

During the year, the various groups helped during visiting hours at the hospital, also mending and salvaging linens and making dressings; in fact assisting in any way required by the hospital.

A library is also maintained in the hospital and newspapers and periodicals are distributed throughout the hospital during the year.

A very fine motto is embraced in the report—"To do our best—and to work together harmoniously for suffering humanity". A very fine motto indeed.

* * *

The Annual Convention of the Women's Hospitals Aids Association of Ontario will be held at the Royal York Hotel, Toronto, October 9th, 10th, and 11th. An interesting program is being arranged and interesting speakers are being procured. Will all affiliated groups plan early to attend?

Beatrice Austin to New York

Miss P. Beatrice Austin, formerly superintendent of nurses at the Hospital for Sick Children, Toronto, has been appointed superintendent at the Seaside Convalescent Home on Staten Island, New York. This is a branch of the Hospital for Ruptured and Crippled, the well known orthopedic hospital in New York City.

Here and There in the Hospital Field

By THE EDITOR

From Costume to Custom

AN interesting story is told of the development of the nurse's uniform on this continent. It is said that in the early years of the training school at Bellevue Hospital in New York City the authorities were quite anxious to have a uniform for the nurses, but that the nurses themselves were opposed to it. The deadlock was broken very happily. One of the best looking girls in the school, a certain Euphemia Van Rensselaer, who was also a member of the inner circle of New York society, was approached by 'the heads". Euphemia went home for a couple of days, consorted with the family dressmaker and returned resplendent in blue and white seersucker with white apron, collar, cuffs and cap. It took the school by storm and in no time at all every girl in the school had blossomed forth in the uniform.

* * *

A Medical "Guest" at Trustee Meetings

An excellent method of familiarizing the medical staff with the administrative problems of the hospital was reported at the recent A.C.S. Hospitalization Conference at Detroit. To each meeting of the Board of Trustees the medical representative on the Board is invited to bring a "medical guest". The plan has had excellent results for many "guests" from the medical staff have obtained a better insight into the administrative side of hospital work.

* * *

A Handy Religious Book

At a recent hospital gathering we picked up a good idea for ensuring the visit of ministers to patients. In this particular hospital the patients are recorded by churches as well as by religions. A loose-leaf book is maintained listing the different churches in the area. On admission each patient's name is recorded under his own church. The ministers, in checking this book, cross off the names of those seen. No record is made in this book of the discharge of the patient, as it is presumed that the minister will keep in touch with the patient after this first notification.

* * *

Unusual Anaesthetic Explosion Fatality

One of the most carefully operated hospitals in the east, the Sloane Memorial Hospital in New York City, had a cyclopropane explosion on April the 15th, which was more severe than at first appeared. The explosion burst the rubber bag containing the gas but there was no flash nor burn observed and the explosion seemed to cause only a slight nose bleed to the patient. As the patient was under the anaesthetic and the doctors could find no other evidence of injury, the minor operation was completed, the procedure taking some ten minutes. After returning to her room the patient began to show respiratory difficulties and died despite the use of oxygen tents and adrenalin. The autopsy revealed that the young woman had suffered a ruptured windpipe.

* * *

Montreal Jewish General Maintenance Campaign Successful

Master Michael Edward Cass had the honour of being the youngest contributor to the Montreal Jewish General maintenance campaign which was successful in reaching its objective of $75,000, a few weeks ago. Michael Edward was born in the hospital during the last few days of the campaign and his grandfather immediately contributed $50 to the fund.

* * *

Controlling Admissions of Non-Staff Cases

Another discussion arose regarding the procedures available to the switchboard operator in controlling admissions sought by doctors whose work is not entirely approved by the medical staff. In one hospital all doctors in the area are listed at the switchboard. Members of the staff and those other doctors whose work is known to be of a high order are listed without comment. Others have either a red star or a black star opposite the name. A "red star" doctor's patient is given a bed and the qualifications committee is notified. When a "black star" doctor makes application, he is told "We are sorry but all of the beds vacant at present have been reserved for the members of the medical staff".

* * *

Reports on Patients to Insurance Companies

Protests have been made from time to time by doctors who have been requested to furnish reports on patients to insurance companies without the consent of the patient. The Canadian Medical Association has taken this matter up with the Canadian Life Insurance Officers' Association and it has been arranged that, in future, no such request will be made of a doctor in Canada until and unless written authority for the giving of such a report is signed by the person concerned. This provision has no bearing on any financial remuneration for the making of such report; that is entirely a matter of arrangement between the doctor and the insurance company representative.

* * *

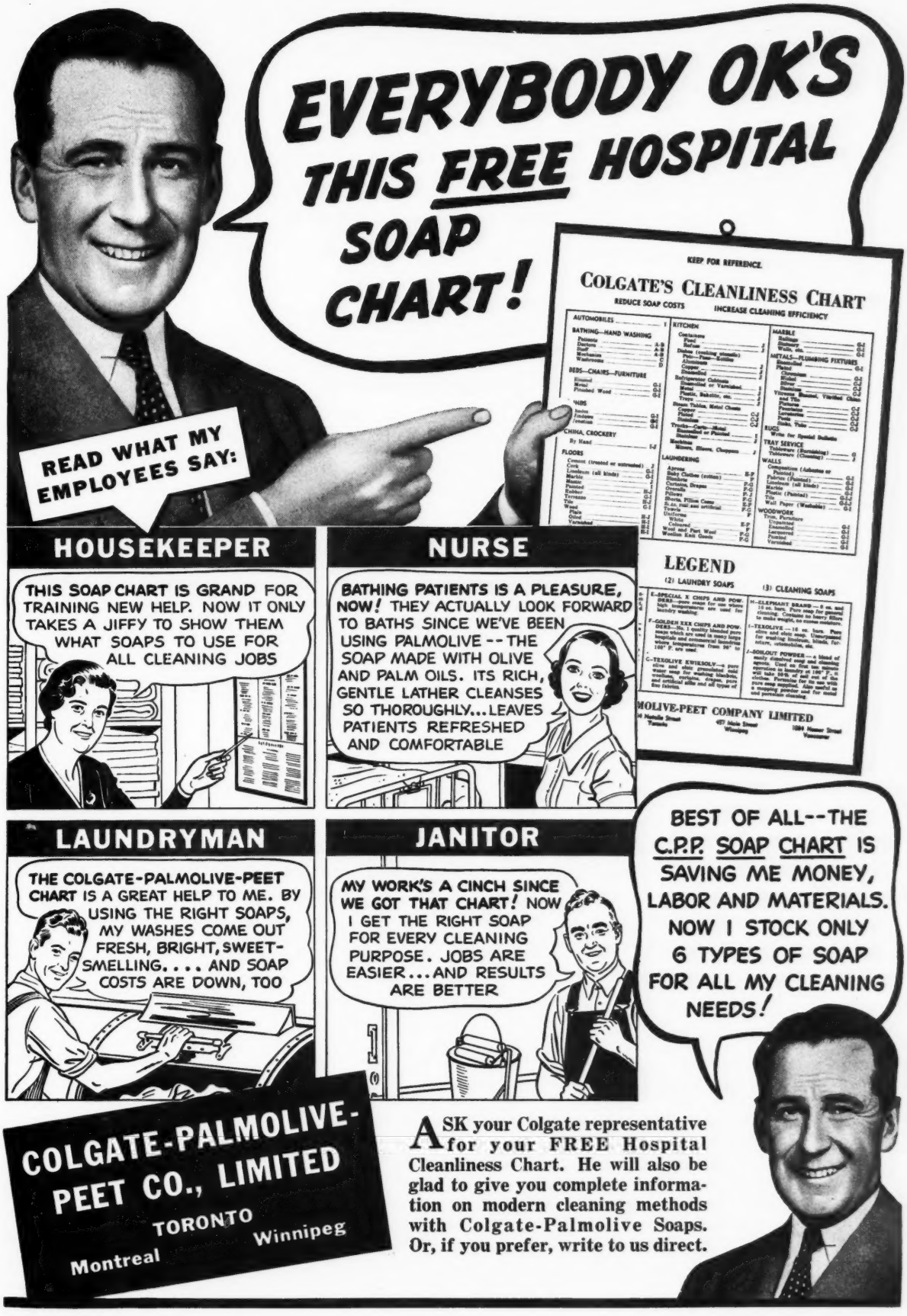
No Narcotic Action Taken

It has been reported that during the past year the Narcotic Division of the Department of Pensions and National Health has not been required to institute action against either a doctor or a pharmacist. This speaks well for the control being established over the narcotic evil in this country. This record, however, does not mean that it has not been found necessary to suspend the privilege of issuing narcotics for some.

* * *

Noted Viennese Ophthalmologist Now in Edmonton

One of the best known specialists in Vienna, Dr. Kurt Fuchs, Ophthalmologist and otolaryngologist has recently been added to the staff of the Royal Alexandra Hospital in Edmonton. Like many other famous teachers in the University of Vienna, Dr. Fuchs was forced to leave Vienna and has taken up residence in Edmonton.


EVERYBODY OK'S THIS FREE HOSPITAL SOAP CHART!
READ WHAT MY EMPLOYEES SAY:
KEEP FOR REFERENCE
COLGATE'S CLEANLINESS CHART
REDUCE SOAP COSTS
INCREASE CLEANING EFFICIENCY
LEGEND
(2) LAUNDRY SOAPS
(3) CLEANING SOAPS
HOUSEKEEPER
THIS SOAP CHART IS GRAND FOR TRAINING NEW HELP. NOW IT ONLY TAKES A JIFFY TO SHOW THEM WHAT SOAPS TO USE FOR ALL CLEANING JOBS
NURSE
BATHING PATIENTS IS A PLEASURE, NOW! THEY ACTUALLY LOOK FORWARD TO BATHS SINCE WE'VE BEEN USING PALMOLIVE -- THE SOAP MADE WITH OLIVE AND PALM OILS. ITS RICH, GENTLE LATHER CLEANSES SO THOROUGHLY... LEAVES PATIENTS REFRESHED AND COMFORTABLE
LAUNDRYMAN
THE COLGATE-PALMOLIVE-PEET CHART IS A GREAT HELP TO ME. BY USING THE RIGHT SOAPS, MY WASHES COME OUT FRESH, BRIGHT, SWEET-SMELLING.... AND SOAP COSTS ARE DOWN, TOO
JANITOR
MY WORK'S A CINCH SINCE WE GOT THAT CHART! NOW I GET THE RIGHT SOAP FOR EVERY CLEANING PURPOSE. JOBS ARE EASIER... AND RESULTS ARE BETTER
BEST OF ALL--THE C.P.P. SOAP CHART IS SAVING ME MONEY, LABOR AND MATERIALS. NOW I STOCK ONLY 6 TYPES OF SOAP FOR ALL MY CLEANING NEEDS!
COLGATE-PALMOLIVE-PEET CO., LIMITED
TORONTO
Montreal
Winnipeg
ASK your Colgate representative for your FREE Hospital Cleanliness Chart. He will also be glad to give you complete information on modern cleaning methods with Colgate-Palmolive Soaps. Or, if you prefer, write to us direct.

Inspiring Hospital Conference Features A.C.S. Meeting at Detroit

G. A. FRIESEN, Belleville

THE Hospital Conference, an integral part of the Sectional Meeting of the American College of Surgeons, held at the Hotel Statler in Detroit during April, in which the Province of Ontario and the States of Illinois, Indiana, Michigan, Ohio and Wisconsin, participated, was again a most outstanding success. The fact that 449 registered for the Conference, of whom 57 were from the Province of Ontario, would in some measure substantiate this statement. The momentum which characterizes the preeminent Dr. MacEachern prevailed throughout the meeting. Every hour of the day, which started at 8.00 a.m., and lasted until late at night was taken up with instructive and interesting addresses, discussions and demonstrations, covering all phases of hospital problems.

The problems of small hospitals featured the entire first session under the capable leadership of Graham L. Davis of the Kellogg Foundation of Michigan. One of the most interesting presentations at this session was given by Miss Helen L. Potts of Woodstock, Ontario, on the subject of "Hospital Personnel". Those who heard Dr. C. E. Smith, Chief of Staff of the DeKalb Hospital in Illinois, expound on Medical Records, might readily believe in Utopia. In this institution a complete history of every patient is obtained before surgical interference is permitted and the surgical supervisor has the authority to delay surgery except in emergency cases until this regulation has been complied with.

The general session on Monday afternoon was particularly interesting. Speakers included such outstanding authorities as Arthur W. Allen, M.D., Vice Chairman of the Board of Regents, American College of Surgeons; George P. Muller, M.D., President of the American College of Surgeons; Harvey Agnew, M.D., Secretary, Department of Hospital Service, Canadian Medical Association; Robin C. Buerki, M.D., Director of Study, Commission on Graduate Medical Education; Sister M. Berenice, R.N., Dean, College of Nursing, Marquette University; Malcolm T. MacEachern, M.D., Associate Director, American College of Surgeons; Frank E. Adair, M.D., Attending Surgeon, Memorial Hospital, New York; and Robert H. Kennedy, M.D., Associate Clinical Professor of Surgery, Columbia University College of Physicians and Surgeons.

The usual lively Round Table took place in the evening at the Providence Hospital; those who have been in attendance when that trio, Dr. MacEachern, Dr. Agnew and Dr. Buerki, lead such conferences will appreciate the interest displayed in this part of the programme.

"Professional Accounting as a Means of Controlling Clinical Work" was a very thought provoking talk by Dr. T. R. Ponton, Editor of Hospital Management. As a result of Dr. Ponton's untiring efforts in promoting this type of work there is a growing tendency towards the acceptance of a Medical Audit as a necessary part of efficient hospital administration.

The Group Conferences, each directed by a team of leaders, were exceptionally well received. This may be due to the fact that the groups are smaller, which permits a more detailed discussion of the subject in which those present are primarily interested. We attended the one directed by Alden B. Mills, Managing Editor of the Modern Hospital, on "Public Relations of the Hospital". Mrs. Margaret Rhynas and Mr. Carl Flath assisted Mr. Mills in conducting this conference and much enthusiasm was shown for the work of women's auxiliaries after Mrs. Rhynas's remarks.

The value of inspiring meetings of this type cannot be overestimated. Not only do we derive food for thought, but the renewing of acquaintances and making of new friends in itself makes one's attendance well worth while.

Do We Take Our Power Plant Problems Seriously?

Surveys show that hospitals spend from three to nine per cent of their total yearly expenditures for fuel and power. Assuming that 6% is an average and that half of it is wasted it means that 3% of total hospital expenditures are wasted.

There are three causes of waste:

1. The financial set up is such as to make it difficult to obtain money for purposes the benefits of which are not obvious to physicians, the donating public or the potential patient. You never hear of endowing zone control or an evaporative condenser, yet the money necessary to endow a bed might, if used for such equipment, save enough to equip not one but two or three.

A second basic cause of waste is the failure to secure a thoroughly trained engineer, put him in a position of real authority and pay him the market value of his servcies.

The third cause of waste is the lack of an adequate power cost system and refusal to install the meters necessary for such a rational cost system.

The first step in cutting power service costs is to put in some meters, starting with those which will show the largest savings for the smallest investment. As a starter the following are suggested—hot water and cold water to laundry, boiler feed water, oil fuel to boiler.

A more complete equipment and one that will give astounding savings is to divide the plant either by building or by management groups, and meter separately to each the cold water, the hot water, the electricity and the steam. Set up a unit cost for each of these services and charge the cost of each to the department using it. The consciousness of each executive that he will receive credit for savings made will so decrease waste of these utilities that they will often pay for themselves in the first year, certainly in two years.

In heating, change to vacuum system is likely to be found an economy and in one case "zone control" reduced the heating cost by 60% of the investment required.

In the laundry there should be a meter for the cold water, for hot water and for steam. Steam meters

are rather expensive and if not possible to install at first the two water meters should be installed in any case. Then the laundry manager should be informed monthly as to the savings made both in gross and in terms of savings per pound of wash.

—Abstract from *Do We Take our Plant Problems Seriously, and Why?* Philip W. Swain, Editor, Power. Hospital Abstract Service, Chicago.

Red Cross Hospital Swept by Fire

All patients were removed to safety when flames swept through the 14-bed Canadian Red Cross Hospital at Thessalon, Ont., early last month.

How Does this Compare with Your Record?

The following data are condensed from a review of acute surgical appendicitis treated during a five year period at St. Michael's Hospital, Toronto:

Total number of cases	340	Operative Procedure:	
Average duration of illness	51 hrs.	Appendectomy in	339 cases
Deaths	12	Drainage instituted in	44%
Mortality rate	3.5%	Average time for drain..	8.7

Analysis of types:	**Cases**	**Deaths**	**Mortality**
Acute	254	1	0.4%
Acute local peritonitis	17	1	5.7%
Acute general peritonitis	45	7	15.5%
Appendiceal abscess	24	3	12.5%

Book Reviews

HEALTH INSURANCE WITH MEDICAL CARE. THE BRITISH EXPERIENCE. Douglass W. Orr, M.D., and Jean W. Orr. Foreword by David Lloyd George. 263 pp. $2.50. The MacMillans in Canada, Toronto. 1939.

This book is a narration of factual data, observations and experience on British health insurance, which indicates a somewhat different approach. The authors are Americans, the husband a recent medical graduate and his wife a young social worker. They made their study on a Barnett Fellowship.

Thanks to the sane advice of the British Medical Association they did not consult Harley Street, which has no intimate contact with panel practice, but got out and visited panel doctors everywhere. Much of the material included in the book is made up of direct quotations from those visited, with, of course, full explanations of schemes and arrangements encountered.

The report is distinctly in favor of the British system. While the lack of prolonged personal contact with the economics of sickness, as would be in the case with older writers, has lessened somewhat the perspective that only such experience can give, the fact remains, nevertheless, that here is a book which is the result of adequate personal investigation, reveals sound observation and shrewd judgment and is apparently a fair statement of fact.

* * *

MICROBIOLOGY AND PATHOLOGY. By Charles F. Carter, M.D., Director, Carter's Clinical Laboratory, Dallas. 2nd edition. 755 pp. Illus. Price $.50. C. V. Mosby Co., St. Louis. McAinsh and Company, Ltd., Toronto.

This new edition brings up to date the earlier edition of this practical work. The contents are divided into two portions, one dealing with microbiology and the other with pathology. It follows the outline prepared by the National League of Nursing Education. There are numerous illustrations, including 25 colour plates. This work could be recommended for the library of the school for nurses.

* * *

ANATOMY AND PHYSIOLOGY LABORATORY MANUAL AND STUDY GUIDE. Barry Griffith King, Ph.D., Assistant Professor of Physiology, College of Physicians and Surgeons, Columbia University, New York, and Helen Maria Roser, B.A., R.N., Instructor in Nursing, Department of Nursing, Columbia University, New York. 273 pp., 63 illustrations. Paper Cover, $3.00. W. B. Saunders Company. Canadian Agents: McAinsh & Co., Limited, Toronto. 1939.

This laboratory manual and study guide is compiled on the basis of active participation by the student herself. It can be used for animal experimentation, as full directions for experiments illustrating basic principles are given. Ample illustrations are provided. The exercises follow the *Curriculum Guide for Schools of Nursing*. It would appear to be the type of manual which makes learning easy and which should be able to hold to a high degree the attention of the mentally fagged student nurse.

The Bright Side of Welfare Work

Woman and house neat but bare. Man has ulster on his stomach.

Couple breaking up home, friends helping.

Milk needed for the baby and father is unable to supply it.

Until a year ago this applicant delivered ice and was a man of affairs.

Couple have been completely stripped. Now barely able to get along.

These people are extremely cultured. Something should be done about their condition.

Man has diabetes and is insulated twice daily.

Couple's only source of income is four boarders all out of work. They owe $600.

Man aggressive—has nine children.

Nice, quiet home family. Dorothy has been out since July.

Roomer pays no board as he usually acts as godfather.

The people have religious pictures all over the place, but seemed clean, however.

Woman says they are a delicate family and must have steamed apartment with eggs and oranges.

Applicant has one child, Lilian, who is three months old and owes 12 months rent.

Saw woman. She has seven children. Husband a veteran.

Woman still owes $45 for a funeral she had recently.

Man hit by automobile—speaks broken English.

This woman is ill, being treated. The gas has been turned off.

—From health department records, taken from records of social workers in Florida.

COMING CONVENTIONS

May 13-16—Refresher Course on Hospital Social Work, School of Nursing, University of Toronto.

May 17-18 — Ontario Society of Radiographers, Toronto.

June 17-21—Catholic Hospital Association of the United States and Canada, St. Louis, Mo.

June 27-28 — Nova Scotia and Prince Edward Island Hospital Association. (Unconfirmed.)

July 3-4—New Brunswick Hospital Association.

August — Maritime Conference, Catholic Hospital Association.

Aug. 28 - Sept. 11—Eighth Annual Institute for Hospital Administrators, Chicago.

Sept. 1-5 — New England Institute of Hospital Administration, Harvard Medical School, Boston, Mass.

Sept. 16-20—American Hospital Association, Boston, Mass.

Oct. 8-9—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto.

Oct. 9-11—Ontario Hospital Association, Royal York Hotel, Toronto.

October—Manitoba Hospital Association.

October—Saskatchewan Hospital Association.

October—Alberta Hospital Association.

October—British Columbia Hospitals Association.

October 21-25—American College of Surgeons, Stevens Hotel, Chicago.

Oct. 28 --Nov. 9—Course in Hospital Administration for Nurses, School of Nursing, University of Toronto.

British Columbia Conference of Catholic Hospital Association Formed

A new British Columbia conference of the Catholic Hospital Association, embracing the nine Catholic hospitals and three schools of nursing in the province, came into being at a meeting of Catholic officials.

Rev. Mother Mary Mark, S.S.A., provincial superior, Victoria, was named president. Sister Mary Philip, F.C.S.P., superior of St. Paul's Hospital, Vancouver, is first vice-president; Sister Mary Lelia, C.S.J., superior of the Mater Misericordiae Hospital, Rossland, second vice-president; Sister Columkille, F.C.S.P., superintendent of nurses at St. Paul's Hospital, Vancouver, secretary; and Sister Mary Ruth, S.C.I.P., superior of St. Vincent's Hospital, Vancouver, treasurer.

Sister Mary Walburga, S.S.J., superior of St. Joseph's Hospital, Comox, and Sister Mary of the Visitation, superior of St. Joseph's Oriental Hospital, Vancouver, are executive members.

Archibishop Duke formally opened the preliminary meeting in the name of the bishops of the province.

Rev. Alphonse M. Schwitalla, president of the Catholic Hosiptal Association, said British Columbia's hospitals, because of their relative physical isolation, needed the closest possible union in their work.

Fergus Hospital Temporarily Closed

The Groves Memorial Hospital at Fergus, Ont., was temporarily closed during the last two weeks of April as a precaution against the spread of a streptocccus infection. All patients were discharged or moved to other hospitals.

Interns Take Notice!

The survey questionnaire registering all physicians in Canada, conducted by the Canadian Medical Association on the outbreak of war, resulted in a marvellous response, over 8,500 replies being received, but there was a noticeable shortage of replies from interns. This may have been due to lack of established contact with the interns by the medical offices or due to the feeling on the part of many interns that they had been advised to complete their internship and, therefore, no response was desired.

It is urgently desired that every medical graduate in Canada be registered. These cards are for information only and should be completed by every graduate. Completion of the card expressing willingness to serve abroad or at home does not imply enlistment. If an intern prefers to complete his internship before offering to serve, such should be so stated. The main thing is to register. If cards are not obtainable in your hospital apply either to 184 College Street, Toronto, or to your Division Secretary:

British Columbia—Dr. M. W. Thomas, Medical-Dental Bldg., Vancouver.

Alberta—Dr. Geo. R. Johnson, 336—8th Ave. W., Calgary.

Saskatchewan—Dr. J. G. K. Lindsay, 307 Birks Bldg., Saskatoon.

Manitoba—Dr. E. W. Campbell, 110 Medical Arts Bldg., Winnipeg.

Ontario—Dr. A. D. Kelly, 184 College St., Toronto.

Quebec—Dr. A. W. Young, 1390 Sherbrooke St. W., Montreal.

New Brunswick—Dr. A. Stanley Kirkland, Public General Hospital, Saint John.

Nova Scotia—Dr. H. G. Grant, Dalhousie University, Halifax.

Prince Edward Island—Dr. E. S. Giddings, Charlottetown.

Nurses' Home Addition Opened at Calgary

The new $20,000 wing on the nurses' home at the Calgary General Hospital was recently opened for occupation. The addition provides living quarters for 39 nurses and makes 18 additional beds available for patients in the hospital proper.

Hospital Days and Per Diem Costs in Public General Hospitals Ontario 1900-1938

Year	Population (thousands)	Patients Treated	Days per Caput	Days per No. Pt. Treated	Daily per Capita Cost
1900	2,176	29,572	0.32	24.5	$0.77
1902	2,217	32,862	0.36	24.1	0.81
1904	2,286	38,808	0.40	23.9	0.88
1906	2,355	41,950	0.38	21.6	1.06
1908	2,412	46,100	0.38	20.0	1.26
1910	2,482	52,321	0.40	19.2	1.30
1912	2,572	63,122	0.47	19.3	1.36
1914	2,705	77,765	0.52	18.1	1.64
1916	2,713	98,587	0.61	16.7	1.71
1918	2,744	104,618	0.63	16.5	2.39
1920	2,863	130,382	0.68	14.9	3.16
1922	2,980	129,089	0.65	14.9	3.37
1924	3,059	141,657	0.66	14.3	3.44
1926	3,164	168,621	0.73	13.7	3.50
1928	3,278	196,008	0.82	13.7	3.57
1930	3,386	218,753	0.88	13.7	3.94
1932	3,475	221,464	0.86	13.5	3.68
1934	3,629	230,445	0.87	13.6	3.43
1936	3,690	260,838	0.92	13.0	3.59
1938	3,731	281,771	0.96	12.7	3.70

Red Cross Outposts are included in this table.

Data recently compiled by the Department of Health of the Province of Ontario provides "chapter and verse" for certain observations frequently made about the trends in hospital patronage and costs. From the figures given above it is seen that the number of hospital days per caput of population has exactly trebled since 1900 (0.32 to 0.96); in other words each person in the province now averages approximately one day of hospitalization per year. On the other hand the length of stay for the average patient has been cut in half (24-5 to 12.7). Costs have more than doubled in the last twenty-five years. Comparison with the costs at the turn of the century is still more striking but the more recent figures can be compared with the earliest figures only with reservations as the basis of calculation has changed somewhat over the years.

Heil Hunger!

Heil Hunger is the title of the book by Dr. Martin Gumpert, former head of the Berlin City Dispensary for Deformity Diseases. Dr. Gumpert was a victim of Nazi Jew-baiting and was successful in smuggling public health records out with him when he fled from Germany. He charges that the incidence of venereal disease in the Reichwehr, the German army, has doubled in the last few years, and produced figures to show that while in 1936 75% of the men called up for service in the army were medically fit, the figure had fallen to 55% in 1938.

Scarlet fever cases, he claims, jumped from 79,830 in 1933 to 117,544 in 1937, and diptheria from 77,340 to 146,733 within the same period of time. Dysentery, according to his figures has risen 300 per cent. Despite Hitler's efforts to raise the marriage rate, it is said that marriages were only 8.9 per 1,000 in 1937 as compared with 12.2 in 1934.

Price Trends (On basis 1926 = 100)

	Yearly Average 1938	March 1939	Feb. 1940	March 1940
Building and Construction Materials	89.1	87.4	94.0	94.7
Cost of Living		83.1	85.2	
Consumers' Goods (Wholesale)	77.2	74.1	82.7	83.0

Construction

The Regina City Council has authorized a bank loan for the Regina General Hospital, which will provide necessary funds for new equipment for the hospital and improvements for the nurses' home.

* * *

Excavation work has begun on the site of the proposed Mount St. Mary Hospital in Victoria, which is being built by the Sisters of St. Ann. H. Whittaker is the architect.

* * *

The town council of Fort Frances, Ontario, has passed a resolution providing the offer of necessary land for a hospital site. The land is to be given free, subject to the condition that construction be begun on the hospital building within the year. The Grey Nuns Society of St. Boniface is reported to be considering erection of a hospital in the town.

* * *

Tenders have been called for the proposed new Shaughnessy Military Hospital, to cost about $650,000. The hospital is to be of fireproofed, reinforced concrete construction.

Securing Personnel in Small Hospital

(Continued from page 26)

bined service. The record librarian may include with her duties the secretarial work of the administrator. The x-ray, clinical laboratory, and physical-therapy, technical work, can be handled by one trained technician. X-ray and physical-therapy may be combined and laboratory and medical records may be combined. The laboratory technician may be also a graduate pharmacist and have charge of the pharmacy department, or the pharmacist may be assistant x-ray technician. The dietitian can successfully include housekeeping responsibilities and maid service under her supervision. Housekeeping and the sewing room may be a combination service. The laundry department may have charge of the mending and the distribution of linens. The mechanical department head may also supervise the maintenance department and have charge of the male employees. The gardener may have full time work by being employed in maintenance or other service during the winter months. Janitor, cleaner and orderly service may be combined in different ways.

In the nursing department there are many combination services which work out to advantage in the small hospital. The administrator probably has to assume the greater combination of duties. She may have to include one or more of the many departments under her direct supervision. Care should be taken though, that she does not carry so many detailed responsibilities that her administrative duties suffer in comparison. A combination of duties should be advantageously arranged to the satisfaction of both the hospital and the personnel, depending on the volume of work and the co-operation between departments.

The satisfied patient is the best advertisement for the hospital, and to bring to the patient the type of service which creates satisfaction we must provide working conditions which will attract and keep with the institution, in all departments, a staff who will maintain a continuous high standard of efficiency.

Training in Hospital Administration

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a Bachelor of Science degree. Yale is considering a graduate course. The University of St. Louis has a four-year course patterned after the ambitious curriculum report* of the American College of Hospital Administration.

A.C.H.A. Curriculum

This proposed program is a most comprehensive one. It presumes that the administrator of the future should have had an education equivalent to that demanded for the arts degree. The course provides in the Bachelor of Science curriculum for:

(a) A general education equivalent to two full years in a preparatory college, covering languages, philosophy, psychology, science and history;

(b) Basic professional work equivalent to a year of college work, in accounting and finance, management and organization, and in statistics; and

(c) Professional studies of one year's equivalent in sociology, socio-legal courses and in hospital administration.

This would be followed by a one year administrative internship. Those desiring to go on for the Master's degree would take one to three years of study in a selected administrative activity. This would apply to laymen or nurses. For medical graduates a modified course, covering the essentials, is recommended. This, of course, is only a guide, but it does indicate the trend toward full and adequate preparation.

Considerations

Obviously, in this evolution from an ill-defined occupation to a highly specialized profession, two features become apparent:

(a) the transition will be of necessity a gradual one, and

(b) educational facilities must be varied to suit individual needs and opportunities for study.

Educational requirements must take cognizance of the fact that four types of individuals, all with varying backgrounds, comprise our administrative group—medical men, nurses, laymen and nuns.

Moreover two broad initial approaches are possible:

(a) to set up courses of study of varying type and duration, and

(b) to recognize by degree or restricted membership, those whose qualifications and attainments indicate a high degree of training or ability.

Great Britain and the United States for several years have followed approach "b"; more recently, however, and particularly in the United States and Canada, varying types of educational facilities as under approach "a" have been set up.

Courses must be developed to meet the needs of all four types of administrators—nurses, laymen, doctors, religious sisters. All four types of background contribute to the wealth of the administrative field as a whole and all four are needed for the future.

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*University Training for Hospital Administration Career. Report by the Committee on Educational Policies (Dr. M. T. MacEachern, Chairman) of the American College of Hospital Administrators, Chicago, 1937.

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Particularly must we educate the administrator of the future to give leadership. With such kaleidoscopic changes in our social fabric it is obvious that the many changes already experienced in our hospital systems will be followed by others. Only the most sagacious leadership on the part of our hospital leaders can guide us through the shoals and protect the interests of the sick whom we serve.

Recognition of Qualification Essential

The actual training of the administrators, however, is but part of the problem of higher educational standards. We still have two big tasks:

(1) To educate governments and hospital boards to demand adequate training as a *sine qua non* in making *all* administrative appointments, and

(2) In some countries, to put the administration of the hospital in the hands of the superintendent, or house governor or secretary, to whom it rightfully belongs, rather than have him function merely as a clerk or admitting officer.

Unless we can completely eradicate the appointment of chief executive officers on the basis of political patronage or friendship rather than of ability, unless we can give the administrator the full responsibility and respect which his difficult position warrants, and unless we can remunerate him in accordance with his responsibility, we cannot expect our most intelligent doctors, nurses and business men to devote themselves, in larger numbers, to the career of hospital administration. Only when adequate training and qualification become essential for any worthwhile appointment can we expect the rank and file of the oncoming generation of hospital administrators to take the longer and more arduous courses now being developed.

Wood's Floor Polishing and Scrubbing Machine

G. H. Wood & Company Limited announce, in this issue, their new Floor Polishing and Scrubbing Machines, which are already in use in many hospitals, and where we understand they are giving satisfaction.

Wood's Floor Machines are so constructed that they will go under beds, desks, and other furniture, and do a thorough scrubbing and polishing job. The machines are entirely gearless, and therefore noiseless.

Self-closing, All-Steel, Waste Receptacles

Wood's Self-Closing Waste Receptacles provide an excellent medium for the reception of waste paper and other refuse. They are fireproof, and obviously conducive to tidiness and cleanliness.

They are available in six standard sizes, all equipped with either duck bag or galvanized metal liners, thus facilitating the removal of waste materials.

The receptacles are equipped with two self-closing doors, both of which operate independently of the other, so that two people can use the receptacle at the same time. They are ideal equipment for public washrooms, kitchens, and elsewhere.

G. H. Wood & Company, Limited, Toronto, would be glad to send you full details upon receipt of your request.